STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING _____ B. WING _____	09/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	**8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey and a State Residential Licensure Survey. This visit was in conjunction with the investigation of complaint IN00097082. Survey dates: September 25, 26, 27, 28, & 29, 2011 Facility number: 000191 Provider number: 155294 AIM number: N/A Survey team: Christi Davidson, RN-TC Diana Zgonc, RN Courtney Hamilton, RN Connie Landman, RN Census bed type: SNF: 60 Residential: 26 Total: 86 Census payor type: Medicare: 24 Other 62 Total: 86 Sample: 35 Forum at the Crossing was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Recertification and State Licensure Survey. Forum at the Crossing was found to be in compliance with 410 IAC	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed 9/29/11 Cathy Emswiller RN	F 000		